DEPARTMENT OF HEALTH AND HUMAN SERVICES	• ,	FORM APPROVED OMB NO. 0938-0193
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TRANSMITTAL AND NOTICE OF APPROVAL OF	1. TRANSMITTAL NUMBER A	CNMI
STATE PLAN MATERIAL	WO 10-NO4A	
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE 1-01-12	
5. TYPE OF PLAN MATERIAL (Check One):	•	
NEW STATE PLAN AMENDMENT TO BE	CONSIDERED AS NEW PLAN	XAMENDMENT
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AME	NDMENT (Separate Transmittal for each	n amenament)
Z BEDERAL STATISTRIEGULATION CITATION:	1. LEDEKAT DODOGE BARANA.	
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for outpatient hospital services.	O PAGE NUMBER OF THE SUPER	SEDED PLAN SECTION
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: ATTACHMENT 4.19B - Pages 1 to 4.	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):	
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10. SUBJECT OF AMENDMENT: COST REIMBURSEMENT FOR MEDICAID HOSPITAL OUTPATIENT SERVICES. 11. GOVERNOR'S REVIEW (Check One): X GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL The Governor's Office does not wish to review the State Plan Amendment.		all the section of th
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